Division of Integrated Care:

CORRECTIVE ACTION PLAN

MCO Name: Optima Health Community Care	Date: 2/27/18	Contract Cycle: CY2017-2018
MCO Instructions: Please provide detail on each of the non-compliance item(s) and how the MCO will address issues relating to this area in the future.		

I. ISSUE / PROBLEM DEFINITION (Be specific – quantify if possible)

On 2/13/18, DMAS issued a CCC Plus Program Corrective Action Plan request. This request was based on the following areas requiring improvement:

- Area 1: Unreliable and Inaccurate Dashboard Data
- Area 2: Untimely Claims Payment
- Area 3: Failed File Transfer to PPL
- Area 4: Lack of Generating Timely Continuity of Care Authorizations
- Area 5: Untimely Payment of Specialized Care Claims

On 1/19/18, Randy Ricker, VP MLTSS and Audrey Folmer, Director Contract Management and Integration met with Tammy Whitlock, Director Integrated Care; Jason Rachel, Integrated Care Manager; Elizabeth Smith, Compliance Supervisor; Karen Kimsey, Deputy Director of Complex Care; Mathew Behrens, Policy Supervisor; Sandra Brown, Care Management Unit; and Nicole Martin, Program Manager Long Term Care to discuss DMAS' concerns about the above areas. At that time, DMAS provided a document with comments on Optima Health's Top 3 for Consumer Directed Services and on Optima Health's general operations. In addition, DMAS provided trending graphs for total paid claims, claims pended for manual review, paid clean claims that exceed 14 days to resolution, and paid clean claims that exceeded 30 days to resolution.

The identified issues were well known to Optima Health as they had been self-identified and discussed with DMAS during weekly calls. Optima Health initiated intense interventions upon identification of the issues. These interventions are discussed in the information in this section and on the attachments.

Upon receipt of the written Corrective Action Plan Notice, Randy Ricker and Audrey Folmer, and Donna Pillatsch, Director of Compliance met to discuss a response plan. On 2/14/18, a Steering Committee meeting was held with the following attendees:

- Randy Ricker, VP MLTSS
- Audrey Folmer, Director Contract Management and Integration MLTSS
- Other names redacted by Optima
- Donna Pillatsch, Director Compliance

Division of Integrated Care:

- Other names redacted by optima

The Steering Committee directed those in attendance to:

- Provide immediate comments on the content of the Corrective Action Plan Notice.
- Establish a process for asking questions, obtaining information, and identifying needed resources.
- Identify parties responsible for each area of concern including a lead person.
- Identify a response format including format for project plans to include milestones, deliverables, and due dates.
- Establish response deliverable dates including allocation of review time by senior leadership.
- Establish daily touchpoint meetings to discuss progress, barriers, and needed resources.

Optima Health would like to submit the following information on the issues identified by DMAS and requiring this Corrective Action Plan.

Area 1: Unreliable and Inaccurate Dashboard Data

This issue was identified in early September 2017 and was reported by Optima Health to DMAS during the Weekly Implementation Meetings. Optima Health launched the CCC Plus Program using a third-party software package developed by Optima Health utilizes to manage Care Management functions including:

- Assigning Care Coordinators with the appropriate skill sets to enrolled membership, based upon each member's associated sub-population, health risks, and geographic location within the State of Virginia.
- Capturing Health Risk Assessments (HRA) performed by each member's assigned Care Coordinator.
- Developing "Custom" Integrated Care Plans (ICP) in collaboration with the members and their associated family members.
- Authorizing medical, behavioral, and Consumer Directed Services on behalf of the members, based upon their medical, behavioral, personal care and environmental needs.
- Documenting meetings with the Inter-Disciplinary Care Team (ICT) comprised of the member and/or their designated representative, the Primary Care Physician and Clinical Specialists involved with the member's overall care.
- Monitoring and tracking the Care Coordination of members.

All of the above activities are extracted from the and are used to populate the weekly Enrollment and Authorization Dashboard.

Once Optima Health identified and reported the data inaccuracies coming from Optima Health immediately addressed its concerns with asking the company to research and resolve these issues. After giving an opportunity to address the identified software issues, it became apparent that Optima Health needed to have a more focused Quality Assurance effort staffed with consultants comprised of Data Analysts and System Integration Experts. In November 2017, Optima

Health engaged [redacted] a team of four consultants, who could provide an objective assessment of the overall data and end-to-end process flows involved with integrating Optima Health's Core Member Enrollment and Claims Processing System with the Production Data Warehouse, and [redacted]

Area 2: Untimely Claims Payment

Optima Health provides weekly dashboards to DMAS which include claims processing information. Optima Health staff meets weekly with DMAS to review and monitor these dashboards. The weekly dashboards display the claims processing times and denials at a high level. Claims processing problems were identified in the September 28, 2017 Dashboard Review meeting. The initial identified issue was that Nursing Facilities were having problems submitting claims. While Nursing Facilities had been using [redacted] Optima Health was using [redacted] and had an exclusivity contractual arrangement with this company. Optima Health arranged with [redacted] to have an exception made to the exclusivity contractual requirement and an [redacted] contract was executed in December, 2017.

During the September 28, 2017 Dashboard Review meeting, Optima Health also identified that not all locations for key Nursing Facilities had been loaded into Optima Health's system. Internal review of October 2017 data showed a lower volume of expected pended claims for Nursing Facilities which was an indicator of claims not being submitted. Other indicators of problems with Nursing Facilities was the lack of payment and/or denials on the dashboard and DMAS' report that Nursing Facilities were not receiving payments.

During the September 28, 2017 Dashboard Review meeting, Optima Health reported that it had received a significant number of manual waiver claims which were missing required information or had incorrect information. Examples included waiver service providers submitting incorrect diagnosis, incorrect member information, or that the claim was missing required information. These waiver claims negatively impacted the number of paid clean claims that exceeded 14 and 30 days to resolution on the dashboard report. On September 25, 2017, Optima Health implemented a claims submission portal through [redacted] for the waiver service providers. Optima Health engaged [redacted] our partner who had been contracting and credentialing waiver service providers to establish [redacted] portal access for the providers, and to educate and train waiver service providers on claims submission and the Portal. [redacted] conducted the bulk of the training and set up access for those providers who wanted to utilize the [redacted] portal by the middle of October. [redacted] continues to train and provide access to the [redacted] portal for any new or existing providers who wish to submit claims through the portal.

While reviewing the October 1 - 7, 2017 dashboard, Optima Health reported to DMAS an issue with [redacted] (clearing house) validating the entire HIPPS code from the current Medicaid version 48 causing claim denials and processing delays. Providers were submitting older versions of RUGS codes causing [redacted] to reject the claim based on "bad code". Optima Health provided education to [redacted] regarding only needing the base code and not the entire HIPSS code to process these claims. [redacted] then programmed its system to relax the edits which then allowed the claims to match on the RUGS code and be approved for payment.

In the November 1 -7, 2017 Dashboard Review meeting, Optima Health identified a resource issue regarding claims processors as dedicated claims processors were still in training. The first group of Optima Health dedicated claims processors completed all training for the core types of claims, as well

as Nursing facility and behavioral health, by December 31, 2017. The next wave completed training in January 2018, and the final wave will complete their training by end of February 2018.

In January 2018, Optima Health began managing CMHRS. Optima Health manually loaded over 1,000 providers based on a spreadsheet provided by DMAS. The spreadsheet was loaded manually in order to avoid processing delays for these new providers and services. This list contained many providers who were listed as group providers and not individual providers. When claims were received, they were submitted by individual providers under their individual NPIs. Since providers had been loaded as groups, claims processing timeliness was affected. Optima Health is also experiencing a large number of submitting providers who were not on the DMAS original provider list.

The combination of the problems Optima Health identified over time outlined above have negatively impacted the ability to pay claims timely, especially for Nursing Facilities, Waiver services, and CMHRS. Optima Health is committed to fully addressing all of these issues and to consistently process and pay clean claims within the contractual requirements.

Area 3: Failed File Transfers to PPL

Twelve XML file failures were identified by the Optima Health IT Department during December 2017 and January 2018. These were identified through a report email notification process established with PPL. This notification process alerts Optima Health that a file has failed XML validation and provides the IT Department with the specific reasons for the failure. The Corrective Action notice references the same XML file errors that had previously been identified, corrected, and re-submitted.

Area 4: Lack of Generating Timely Continuity of Care Authorizations

Optima Health identified an issue with the timely generation of continuity of care authorizations in early September 2017. Once identified, Optima Health's Clinical Care Team proceeded to launch an internal investigation which included working with the Optima Health Information Technology Department and the third-party software vendor, [redacted] developed Optima Health's Clinical Care Management System, [redacted]

Optima Health utilizes [redacted] to manage its Care Coordination functions for generating timely authorizations based on the DMAS' Medical Transition Report (MTR) Files. [redacted] is designed to:

- Ingest electronic MTR Authorization Files associated with new members who elect to sign up with Optima Health. These MTR Authorization Files accompany the 834 - Member Enrollment Files, prior to new members' effective enrollment dates. These MTR Authorization Files are intended to ensure active services being provided to members continue without disruption during their transition to a new MCO.
- Assist Optima Health's Clinical Care Team in coordinating members' care by automatically generating authorizations associated with medical, behavioral health and Consumer Directed Services for care that is actively being provided to new members transitioning to Optima Health. This system utilizes the MTR Authorization Files received from DMAS and/or other MCOs.
- Monitor and track the Care Coordination of both existing and new members transitioning their care over to Optima Health in order to ensure that members do not experience any disruption in services based upon their assessed medical, behavioral, personal care and environmental needs.

- Transmit all "approved" authorizations, which have been vetted by the Care Coordination and Utilization Management Teams, over to Optima Health's core Claims Processing System [redacted] to adjudicate incoming claims that require authorizations.
- Transmit all Consumer Directed Authorizations received from [redacted] into [redacted] and to DMAS' Fiscal/Employer Agent, PPL, for processing payments to Consumer Directed Providers.

Optima Health identified there were internal process breakdowns with handling the MTR Authorization Files and the authorization data being passed over to [redacted] and ultimately transmitted over to our core Claims Processing System [redacted] Optima Health immediately engaged both its internal IT resources and [redacted] developers to research and resolve these system integration issues. Realizing the complexity of the issues, Optima Health engaged the services of an external consulting firm, [redacted] to assist both Optima Health IT and [redacted] in resolving the problems. In early November 2017, [redacted] provided four consultants who were Data Analysts and System Integration experts. This enabled Optima Health to obtain objective assessments of the overall data and process flow issues involved with integrating Optima Health's core systems and [redacted]

Area 5: Untimely Payment of Specialized Care Claims

On January 11, 2018 and during the bi-weekly Nursing Facility call with DMAS and VHCA, Nursing Facilities indicated they were now starting to see their regular Nursing Facility claims being processed but were still having problems with their Specialized Care claims submissions. At that time, it was identified that Specialized Care claims which are indicated by revenue code 199 and bill type 65X were not being paid. During the same call on January 11, 2018, Optima Health requested contact information from the facilities who provide Specialized Care services. VHCA provided Optima Health with information for Kissito and Children's Hospital of Richmond. Optima Health met via phone with these providers who provided claim detail and which assisted in determining that their specialized claims were not in Optima Health's system. Optima Health educated the facilities that they could submit claims via secure email until the problem was resolved. Optima Health also asked Steve Ford at the VHCA to communicate with the VHCA membership that Optima Health was willing to meet with providers who were affected by this issue and offer an advanced payment option. Optima Health reached out to [redacted] to determine why these claims were being rejected and identified an edit was preventing the acceptance of bill type 65x. Optima Health requested [redacted] to modify the edits to accept bill type 65x and on February 1, 2018, [redacted] confirmed their edits had been relaxed and bill type 65x would be accepted. On February 2, 2018 Optima Health notified the Nursing Facilities, DMAS, and the VHCA on the bi-weekly call that these edits had been revised and to please start submitting the Specialized Care claims electronically. On the February 15, 2018 bi-weekly call, one of the Specialized Care providers shared they were able to submit their claims electronically.

II. DESCRIPTION OF ROOT CAUSE EVALUATION PROCESS AND RESULTS

Optima Health implemented an analysis of the root causes for each of the areas identified in the Corrective Action Plan Notice dated February 13, 2018.

Area 1: Unreliable and Inaccurate Dashboard Data

The Consulting Team conducted a thorough analysis of the contributing factors causing the data inaccuracies identified in the data extracts generated from [redacted] relies upon two critical data sources to be successfully loaded and synchronized:

- Accurate member Enrollment Data being transmitted to [redacted] from Optima Health's Member Enrollment System on a daily basis.
- Membership Sub-Population Classifications run within Optima Health's Data Warehouse Environment and submitted over to [redacted] on a regular basis.

Both of these data sources drive the Care Coordinator Assignments and timelines for conducting members' Health Risk Assessments and subsequently developing appropriate Integrated Care Plans for members managed within [redacted] Unfortunately, Optima Health's consultants, [redacted] found that [redacted] have not consistently loaded all of the Member Enrollment Data that was transmitted to [redacted] The logic used to classify the members into the appropriate Sub-Populations was not consistently applied, thus, some of the members were not correctly classified. This impacted the timelines configured within [redacted] It was also discovered there were timing issues with synchronizing the data feeds being passed over to [redacted] All of these have been identified as root causes and the Area 1.A Project Plan addresses the actions for correction.

Area 2: Untimely Claims Payment

As the dashboard began to demonstrate a trend in untimely claims payment in late September 2017, Optima Health created a Claims SWAT Team. This Team began work mid-October 2017 and continues to meet weekly. The SWAT Team is led by [redacted] and Randy Ricker, VP MLTSS. The team includes [redacted]

This Team systematically tackles the issues impacting timely claims payment and identifies resources needed to address the challenges.

On November 30, 2017 and in order to assist with addressing provider concerns, Optima Health began to participate in bi-weekly calls with the Nursing Facilities contracted for Optima Health members, the Virginia Health Care Association (VHCA), and DMAS representatives. Optima Health addresses provider concerns by triaging concerns through its Provider Services Team, Network Management, and the Operations Team.

The root causes of these processing delays for Nursing Facility, Waiver, and CMHRS claims are the following:

- Nursing Facilities initially had difficulty submitting claims to Optima Health because they used the clearing house, [redacted] with which Optima Health had no contract.
- Not all locations for key Nursing Facilities were originally loaded in the Optima Health system.
- More manual waiver claims were received than expected, with a significant number of them missing key information or having incorrect information.
- Edits for RUGS codes used by Optima Health's clearing house, [redacted] was a more updated version than that of the providers. This caused claim rejections and denials.

- Length of time and level of complexity for training Optima Health's dedicated claims processors took longer than expected.
- Volume of CMHRS claims was greater than expected for individual providers who were not on the list provided by DMAS or who submitted claims as individual providers instead of under the loaded group.

Area 3: Failed File Transfers to PPL

Twelve XML file failures were identified by the Optima Health IT Department during December 2017 and January 2018 after being reported via the email notification process established with PPL. The XML errors were immediately researched and traced to two root cause issues:

- Participant file had invalid Medicaid ID as a result of an additional character being added during a process established for terminating duplicate members.
- Manual generation of authorization files resulted in keying errors that manifested in field errors on the XML file(s).

The majority of the file errors were the result of manual actions being taken by the Optima Health team to process authorizations to allow pended timekeeping exceptions to process successfully. All file failures noted above were corrected and successfully re-submitted to PPL.

Area 4: Lack of Generating Timely Continuity of Care Authorizations

Optima Health's consultants, began its engagement with interviewing the key Optima Health IT resources responsible for retrieving the transmitted MTR Files from DMAS and sending them to order to load the MTR Authorizations into and Optima Health staff conducted a thorough analysis of the contributing factors causing the delays in generating Continuity of Care Authorizations. This included reviewing the raw data files coming from DMAS, which initially gets processed by Optima Health's Data Warehouse Team and ultimately send to for loading into also analyzed the Error Reports of Authorizations being rejected by Optima Health's core Claims Processing System when attempts to send them to The results reported by identified the following root causes contributing to the delays in successfully generating Continuity of Care Authorizations:

- The data quality and consistency contained within the MTR Authorization Files which DMAS sends to Optima Health from the other MCOs varies significantly. This makes it difficult for Optima Health's IT Department to build an automated load program to ingest MTR Files into the Data Warehouse environment and requires significant manual intervention to address the data anomalies encountered from each of the MTR Files.
- had not consistently loaded the MTR Files, which are sanitized by Optima Health's Data Warehouse Team and then are posted to FTP Site for ingestion into . Once received, applies some referential integrity checks on the providers referenced within the MTR Authorization, validating the provider's NPI against Optima Health's Provider Master File. This file is then loaded daily from into , capturing any provider configuration changes maintained within Optima Health's core Claims Processing System. The provider updates sent over to from includes participating and non-participating providers configured within

Any authorizations, which have associated providers who are not found on the Provider Master File loaded from [redacted] get flagged and the provider's NPI and name are inserted into the Authorization's Comment Field. Claims Operations staff then handle these from a Provider Configuration perspective. Further, [redacted] overwrites the provider's NPI on the authorization with a value of "UNONE" and/or "HNONE", depending upon whether the authorization is for Outpatient or Inpatient Services.

The same process is done with behavioral health and CMHRS authorizations if the associated provider data referenced on the authorization does not match up to the Provider Master File loaded into [redacted]. For behavior health and CMHRS authorizations, the provider's NPI and name are captured in the Authorization's Comment Field and the NPI Number is replaced with a value of "OHNONE" and/or "OUNONE". This distinguishes between Inpatient Behavioral Health Providers and Outpatient BH Providers.

- Optima Health's [redacted] ystem occasionally rejects Continuity of Care Authorizations sent over from [redacted] for varying reasons including Invalid Authorization Types or Missing Authorization Super Types, and Authorization Unit Values do not always align with the Dates of Services specified. Some authorizations have also been rejected by [redacted] due to the Care Coordinator's User ID not being set up properly within [redacted] This issue has been corrected by ensuring Care Coordinators are assigned User IDs in both [redacted], including their required roles within both Systems. Optima Health has submitted change requests for [redacted] to tighten the data edits within [redacted] to ensure all required data elements for authorizations are present, before the authorizations are transmitted to [redacted] for ingestion; preventing any authorization rejections from occurring in the future.
- Although Optima Health currently posts Continuity of Care Authorizations onto our Member Portal, there is currently no automated mechanism to generate Member Notification Letters in writing for new members. An automated process is being developed by [redacted] (Refer to the Action Steps and Timeframes for Area #4 for further details).

Although the root causes outlined above span multiple systems, Optima is committed and feels confident that we can address these issues using a multi-pronged approach in resolving them, as described in Area #4's Action Steps and Timeframes Section.

Area 5: Untimely Payment of Specialized Care Claims

Optima Health determined that the root cause of the Untimely Payment of Specialized Care Claims was due to claims being rejected based on edits which [redacted] (Optima Health's clearing house) had in place. Optima Health worked with [redacted] to update the edits to allow electronic submission of Specialized Care claims with 199 revenue code and bill type 65X. In order to facilitate payments, Optima Health allowed the facilities to securely email the Specialized Care claims. These were manually processed and paid until the electronic process was programmed by [redacted] All electronically submitted claims which are pended for any reason are then handled by a claims processor who is trained in that claim processing specialty. On February 1, 2018, [redacted] certified to Optima Health that the electronic processing was successfully functioning.

III. ACTION STEPS AND TIMEFRAME(S)

Division of Integrated Care:

OHCC is submitting the information below and the attached documents as requested in the Corrective Action Plan Notice (2/13/18).

Area 1: Unreliable and Inaccurate Dashboard Data

The following actions were implemented in order to address the Unreliable and Inaccurate Dashboard Data issue:

- On 1/24/2018, Data and Process Flow Diagrams were developed by Optima Health's consultants, to identify gaps in the process which contributed to the data inaccuracies reported out of relating to the Enrollment Dashboard.
- On 2/1/2018, Optima Health's consultants, worked with the Core Enrollment System Developers and the Developers to ensure all Member Disenrollments and Retroactive Disenrollments were successfully being loaded into
- On 2/15/2018 worked with Optima Health's Data Warehouse Team to correct the Sub-Population Logic to ensure all of the members were properly classified when loaded into
- On 2/16/2018, compared the Member Enrollment Data within the Core System aligned with the members classified within the Data Warehouse, which was successfully loaded into . Thus, the Member Enrollment Data and Member Sub-Populations reconciled across all three systems.
- is in the process of building an Interim Enrollment Dashboard which should be completed by February 28, 2018. This dashboard will display reconciled Member Enrollment Data captured within the Member Enrollment System, Member Sub-Populations captured in the Data Warehouse, and modified Extracts containing the Health Risk Assessments and Integrated Care Plans with their associated completion dates. This Interim Enrollment Dashboard will also include historical data that has been rebuilt to accurately reflect work performed since August 2017 to the present month of February 2018.

Please refer to the following attachment for additional details:

- Area 1.A. Project Plan

Area 2: Untimely Claims Payment

The following actions were implemented in order to address the Untimely Claims Payment issue:

- Optima Health received an exception from the exclusive contract with to allow contracting with contract was executed and implemented mid-December, 2017.
- In November 2017, the clearing house edits were relaxed to accept claims based on the 3 digit RUGS code.
- By December 31, 2017, the first group of Optima Health dedicated claims processors completed all training for the core types of claims, as well as Nursing Facility and behavioral health. The next wave of staff completed training in January 2018, and the final wave will complete their training by the end of February 2018.
- During December 2017 and January 2018, Network Management reached out to all Nursing Facilities to assist with billing questions, to establish access to the provider portal, and to facilitate EFT (electronic fund transfer) set ups.

- In January 2018, Optima Health determined additional check runs would positively impact timely payments. The second weekly check run for medical claims was implemented February 1, 2018 and February 22, 2018 for behavioral health claims.
- Training for CMHRS claims will be provided to additional claims processors by the end of February 2018. This will allow Optima Health to address the higher claims volume.

Please refer to the following attachment for additional details:

- Area 2.A. Project Plan

Area 3: Failed File Transfers to PPL

The following actions were implemented in order to address the Failed File Transfer to PPL issue:

- Optima Health created programing changes to restrict Medicaid ID submission to numeric 12 digits on the Participant and Copay XML file to PPL. Testing was completed January 24, 2018 and changes were put into production on February 1, 2018.
- Optima Health created programming changes to create an XML export program for PPL Participant and Authorization files that allow input of a Member ID and/or Authorization ID and produce the exact output of the automated files. This eliminates the need for any manual file creations. Testing began on February 13, 2018 with program changes targeted to be live in production on February 23, 2018.

Please refer to the following attachments for additional details:

- Area 3.A. Project Plan

Area 4: Lack of Generating Timely Continuity of Care Authorizations

The following actions were implemented in order to address the Lack of Generating Timely Continuity of Care Authorizations issue:

- On January 17, 2018, Data and Process Flow Diagrams were developed by Optima Health's consultants, [redacted] These diagrams identify where the processing of MTR Authorization Files breaks down and delays the generation of Continuity of Care Authorizations being successfully transmitted over to [redacted] from [redacted]
- On February 5, 2018, [redacted] worked with both Optima Health's Data Warehouse Team and the IT staff involved with ingesting the Continuity of Care Authorizations from [redacted] These originate from Optima Health's Data Warehouse. This effort identified common issues that span across all three systems. This enabled Optima Health staff and [redacted] to build a list of Change Requests for [redacted] which will reduce the Authorization Rejections being generated when attempting to load the Authorizations from [redacted] into [redacted]
- On February 21, 2018, Optima Health conducted a design session between the Clinical Care Coordination Leadership Team and [redacted] to discuss possible options for addressing the occurrences of non-participating providers referenced on incoming MTR Authorizations failing the validation checks against the Provider Master File. During these discussions, it was determined that a more proactive approach needed to be pursued which included working with Optima Health's Data Warehouse Team to address the processes prior to the MTR Authorizations being sent to [redacted]. A long term solution is being address and meetings are set for the week of February 26th to re-configure [redacted]

- On February 22, 2018, Optima Health held a strategy session with the Care Coordination Leadership Team and the Utilization Management Team to discuss viable options for addressing the need to auto-generate Member Notification Letters for approved Continuity of Care Authorizations. Action items from this meeting resulted in the creation of two Change Requests being written and submitted to the Developers for revisions to the system.
- On February 23, 2018 during the weekly Steering Committee Meetings, the Clinical Care Management Team presented the above Change Requests for addressing auto-generation of Member Notification Letters. The Change Requests were approved and prioritized and the Developers are scoping out the level of effort. This will then be incorporated into the Project Plan.

Please refer to the following attachments for additional details:

- Area 4.A. Project Plan

Area 5: Untimely Payment of Specialized Care Claims

The following actions were implemented in order to address the Untimely Payment of Specialized Care Claims issue:

- Optima Health allowed Specialized Care providers to submit claims via secure email and processed them manually until the edits were updated in on February 1, 2018.
- Optima Health met individually with Specialized Care providers and offered advance payments.
- Effective February 1, 2018, edits in were updated to accept the 199 revenue code and bill type 65X for Specialized Care claims.
- On February 15, 2018 during the Nursing Facility call, Optima Health received confirmation from a participant that Specialized Care claims were being successfully processed.
- Optima Health confirmed that other facilities were also experiencing successfully processing of Specialized Care claims.

Please refer to the following attachments for additional details:

- Area 5.A. Project Plan

IV. IMPROVEMENT BENCHMARK(S) AND TIMEFRAME(S)

Optima Health has delineated benchmarks and time frames in the Project Plans for each area of concern. Please refer to the information under III. ACTION STEPS AND TIMEFRAME(S).

Area 1: Unreliable and Inaccurate Dashboard Data

Optima Health has implemented several audit checkpoints to ensure data transmissions between the various internal systems, which ultimately feed into the target system are continuously monitored. This will ensure that future Enrollment Dashboards will continue to report both reliable and accurate data.

Area 2: Untimely Claims Payment

All Nursing Facilities and all locations have been set up in Optima Health's system. Optima Health has implemented a new claims clearing house, [redacted] to support providers and give more options to submit claims for payment. In addition, Optima Health added a provider portal for all Waiver type claims to be entered online and securely. Optima Health monitors the claims lag daily through Macess lag time reports. The Macess system groups types of claims together (Nursing Facilities, Waivers, CMHRS, Arts, and EI) and provides managers a report indicating the number and age of pended claims. Optima Health managers then assign workload based on the claims' age and the level and type of specialized trained claims processors. This allows Optima Health to better manage the timeliness of claims processing.

The training process for the majority of the claim types received will be completed by the end of February 2018 and will result in having additional, consistent, fully trained claims processing resources. All providers on the DMAS CMHRS list were loaded by the end of December 2017. CMHRS training was provided to claims processors by the end of December 2017. An additional ten staff members will go through full behavioral health claims training to include CMHRS by the end of February 2018.

Area 3: Failed File Transfers to PPL

Optima Health will implement additional monitoring processes to ensure timely and accurate processing of PPL data files by March 9, 2018.

- A file transfer monitoring process has been in place and functioning since go-live. The monitoring process will be upgraded to include the creation of a grid to document XML errors received and subsequent re-transmission to PPL.
- Optima Health has been hosting weekly MCO calls with PPL and DMAS since May 2017. Optima Health representatives have attended all trainings offered by PPL, including the recent session on February 13, 2018.

Area 4: Lack of Generating Timely Continuity of Care Authorizations

Optima Health is implementing several audit checkpoints to ensure data transmissions between the various internal systems. These are critical to ensuring timely generation of Continuity of Care Authorizations. Upon the successful delivery of all Milestones in the Area #4 Project Plan, Optima Health believes that Continuity of Care Authorizations will be timely generated as required.

Area 5: Untimely Payment of Specialized Care Claims

As discussed in previous sections of this document, the root cause for the untimely payment of Specialized Care claims were edits set up in [redacted]. These were updated effective February 1, 2018. This update was communicated at the bi-weekly Nursing Facility meeting with DMAS and VHCA on February 2, 2018. At the February 15, 2018 meeting, a Specialized Care provider confirmed that their Specialized Care claims were successfully submitted electronically. Optima Health confirmed that other Specialized Care providers' claims were processing. Optima Health will continue to monitor these submissions to ensure ongoing successful transmissions.

Optima Health understands the importance of meeting contractual requirements and Federal regulations in order to successfully treat the MLTSS population. Optima Health is committed to working closely with DMAS and to resolving all areas of concern. It submits this and the attached

documents as evidence of the intense work that is being done. Optima Health looks forward to weekly calls focused on informing DMAS of its progress with the Project Plans so that all contractual requirements can be met.

V. CERTIFICATION

The undersigned have reviewed this Corrective Action Plan.

Edward M Ricker

MCO Signature and Title:

February 26, 2018
Date

VI. DEPARTMENT APPROVAL

Karen Kimsey

Department Signature and Title:

March 22, 2018
Date